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<b>MENTAL HEALTH AND AODA</b>	<b>GENERAL INFORMATION</b>	<b>08/94</b>	<b>2H1-001</b>

**A. TYPE OF HANDBOOK**

Part H, Division II, Mental Health and Alcohol and Other Drug Abuse (AODA) Services: 51.42 Board Owned-and-Operated Clinics, is the service-specific portion of the Wisconsin Medical Assistance Provider Handbook. Part H, Division II, includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, prior authorization procedures, and billing instructions. Part H, Division II is intended to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAF).

The information in Part H, Division II of the handbook applies only to providers who are certified as 51.42 Board owned and operated outpatient psychotherapy or AODA clinics.

Hospitals providing mental health and AODA services through a hospital outpatient mental health or AODA clinic are subject to the policies and prior authorization procedures outlined in this handbook. However, the billing information does not apply to hospitals since they use a different claim form. As specified in HSS 107.08(3)(b)2, Wis. Admin. Code, outpatient services performed outside the hospital facility may not be reimbursed as hospital outpatient services. Therefore, clinics which are owned and operated by hospitals, but which are not located at the site of the hospital, must be separately certified as outpatient psychotherapy clinics. These clinics are subject to all policies in this handbook. These clinics must bill services on the HCFA 1500 claim form.

Since HSS 105, Wis. Admin. Code, contains distinct certification requirements for separate programs, agencies providing other types of mental health programs (e.g. day treatment, Community Support Programs) are required to obtain separate WMAF certification for each of these programs. Providers may contact EDS for certification materials. Refer to Appendix 2 of Part A of the WMAF Provider Handbook for information on how to contact EDS. Separate DCS certification is required for each type of mental health program.

Providers who are also certified to provide other WMAF covered mental health/AODA services should refer to the appropriate service-specific handbooks for information on those services. Part H, Division I, is for use by non-51.42 Board-Operated Clinics providing mental health and AODA services. Part H, Division III, is for Mental Health Day Treatment providers. Part H, Division IV, is for AODA Day Treatment providers. Part H, Division V is for Community Support Program (CSP) providers.

Please note that the qualifications, definitions and procedures for psychotherapy differ from AODA treatment and are separately described throughout this handbook.

**B. PROVIDER INFORMATION**

**Eligibility for Certification of Psychotherapy Providers**

In order to be certified as a WMAF psychotherapy provider, one of the following requirements must be met:

A 51.42 Board Owned-and-Operated psychotherapy clinic must be certified by the Division of Community Services (DCS) of the Department of Health and Social Services (DHSS) as meeting the outpatient psychotherapy clinic standards under HSS 61.91 to 61.98, Wis. Admin. Code. Staff providing services which are billed to the WMAF must meet the following criteria but do not need to be individually certified by the WMAF:

A psychiatrist must be a licensed physician under ch. 448, Wis. Stats., who has completed a residency in psychiatry.

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A psychologist must be licensed under ch. 455, Wis. Stats., and be listed or eligible to be listed in the National Register of Health Service Providers in Psychology. A psychologist licensed under ch. 455, Wis. Stats., with the academic credential of a doctoral degree who is not eligible for listing in the National Register, is considered a master's level provider.

A master's degree psychotherapist must be employed by the clinic and must meet the requirements listed in HSS 61.96 (1)(b) or (2), and HSS 61.96(3), Wis. Admin. Code.

**Important Note:** All psychotherapists at 51.42 Board-operated clinics who provide services to recipients who are dually eligible for Medical Assistance and Medicare must be individually certified by the WMAP in order for reimbursement to occur.

**Eligibility for Certification of AODA Treatment Providers**

In order to be certified as a WMAP AODA treatment provider, a 51.42 Board Owned-and-Operated AODA Clinic must be certified by DCS as meeting the outpatient treatment program standards under HSS 61.59, Wis. Admin. Code.

Staff providing services which are billed to the WMAP must meet the following criteria but need not be individually certified:

A physician must be licensed under ch. 448, Wis. Stats.

A psychologist must be licensed under ch. 455, Wis. Stats., and be listed or eligible to be listed in the National Register of Health Service Providers in Psychology. A psychologist licensed under ch. 455, Wis. Stats., with the academic credential of a doctoral degree who is not eligible for listing in the National Register is considered a master's level provider.

A master's degree psychotherapist must be employed by the clinic and meet the requirements listed in HSS 61.96(1)(b) or (2), and HSS 61.96 (3), Wis. Admin. Code.

An alcohol and/or drug counselor must be employed by the clinic and must be certified by the Wisconsin Alcoholism Counselor Certification Board. An alcohol and/or drug counselor who is not certified by the Wisconsin Alcoholism Counselor Certification Board but has a development plan on file does not meet this requirement.

**Certification as Psychotherapy and AODA Treatment Providers**

Providers are encouraged to apply for certification materials through EDS prior to the time of their DCS certification site visit in order to ensure the earliest possible certification effective date.

A 51.42 Board Owned-and-Operated clinic meeting the eligibility requirements for psychotherapy or AODA treatment that wishes to be certified as a WMAP psychotherapy or AODA clinic must contact:

EDS  
Attn: Provider Maintenance  
6406 Bridge Road  
Madison, WI 53784-0006

The clinic is required to submit a copy of the approval letter from the DCS of the DHSS to verify that it has been certified to provide psychotherapy and/or AODA services in Wisconsin.

**Scope of Service**

The policies in Part H, Division II, govern services provided within the scope of practice as defined HSS 107.13 (2) and (3), Wis. Admin. Code. Covered services and related limitations are listed in Section II of this handbook.

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**Reimbursement**

Mental health and AODA providers in non-Board operated clinics are reimbursed for most services at the lesser of the provider's usual and customary charge or the maximum allowable fee established by the DHSS. However, reimbursement rates for some services provided by 51.42 Board Owned-and-Operated clinics are provider-specific. Information about current rates established for 51.42 Board Owned-and-Operated clinics may be obtained by writing to:

Mental Health/AODA Policy Analyst  
Bureau of Health Care Financing  
1 West Wilson Street  
Post Office Box 309  
Madison, WI 53701-0309

Providers are required to bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Further information on billing is found in Section IV of this handbook.

Master's degree psychotherapists and AODA counselors are non-billing performing providers and may not be directly reimbursed for services they provide. Reimbursement for services performed by these providers may be made only to the certified clinic which employs them. Refer to Section IV-F of this handbook for billing instructions.

**Provider Responsibilities**

Specific responsibilities as a provider under the WMAP are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

**C. RECIPIENT INFORMATION**

**Eligibility For Medical Assistance**

Recipients meeting eligibility criteria for the WMAP are issued Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and when applicable, an indicator of health insurance coverage, managed care program coverage, and Medicare coverage.

Medical Assistance identification cards are sent to recipients monthly. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for the WMAP; Medical Assistance identification cards, temporary cards, restricted cards, and how to verify eligibility. Review Section V of Part A carefully before services are rendered. A sample Medical Assistance identification card may be found in Appendix 7 of Part A of the WMAP Provider Handbook.

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**Medical Status**

Medical Assistance recipients are classified into one of several eligibility categories, including qualified Medicare beneficiary-only (QMB-only). These categories allow for a differentiation of benefit coverage.

Additional information regarding medical categories may be found in Section V of Part A of the WMAP Provider Handbook.

**Copayment**

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining mental health and AODA services. The procedure codes and their applicable copayment amounts may be found in Appendix 15 of this handbook.

Providers are reminded of the following copayment exemptions:

- Emergency services
- Services provided to nursing home residents
- Services provided to recipients under 18 years of age
- Services provided to a pregnant woman if the services are related to the pregnancy
- Services covered by WMAP-contracted managed care programs to enrollees of the WMAP-contracted managed care program

Copayment must be collected from the recipient by the provider of service. Applicable copayment amounts are automatically deducted by EDS from payments allowed by the WMAP. Do not reduce the billed amount of the claim by the amount of recipient copayment. Refer to Section IV of Part A of the WMAP Provider Handbook for further information on copayment.

**Managed Care Program Coverage**

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care programs are denied.

WMAP-contracted managed care programs are required to cover all WMAP-covered mental health and AODA services. Further, managed care programs must guarantee that all Medical Assistance recipients enrolled in WMAP-contracted managed care programs have access to all medically necessary outpatient mental health and AODA services. No limit may be placed on the number of hours of outpatient treatment which the managed care program provides or reimburses when it is determined that treatment for mental or nervous disorders, alcohol or drug abuse is medically necessary. Managed care programs may not establish any monetary limit or limit on the number of days of inpatient hospital treatment when it is determined that this treatment is medically necessary. Managed care programs may establish their own authorization procedures.

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For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for mental health and AODA services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, disenrollment and hospitalizations is included in Section IX of Part A of the WMAP Provider Handbook.

**Recipient Eligibility for Mental Health and Alcohol and other Drug Abuse Services**  
As specified in HSS 107.03(15), Wis. Admin. Code, the following recipients are not eligible for services through the WMAP:

1. an individual who is currently in jail or a correctional facility; and
2. an individual 21 to 64 years of age who is a resident of an institution for mental disease (IMD), unless the recipient is 21 years of age, was a resident of the IMD immediately prior to turning 21 and has been continuously a resident since then, unless the individual is on convalescent leave. (If these conditions are met, treatment may be provided up to the recipient's 22nd birthday.) "Convalescent leave" means a resident's temporary release from an IMD to

residency in a community setting, not more frequently than once a year and beginning on the fourth day after release. The trial period of residence in the community must last at least four days but no longer than 30 days, or until the recipient is permanently discharged from the IMD, whichever occurs first.

Any WMAP payments made on these claims must be returned to the WMAP. Medicare claims for coinsurance/deductible are not reimbursable by the WMAP for recipients in an IMD.